

# Current Topics in Law and Policy

## Prosecuting Maternal Substance Abusers: An Unjustified and Ineffective Policy

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This year as many as 375,000 babies may begin their lives harmed by their mothers' substance abuse. As they grow, many of these children will suffer from a myriad of health problems and will impose tremendous financial and social costs on American society. Frustrated by the proliferation of drug babies, the apparent unwillingness of these babies' mothers to abstain from using drugs, and the inability of the social welfare and public health systems to cope with this problem, a handful of prosecutors across the country have invoked criminal sanctions against approximately fifty pregnant substance abusers.<sup>1</sup>

These prosecutors have a particular perception of the problem they confront and of the solution they seek. Like most Americans, prosecutors have been inundated by scenes of tiny, trembling infants, often abandoned and unloved, and apparently damaged for life by their mothers' substance abuse during pregnancy. And, like many Americans, these prosecutors see one cause for all of this suffering: *in utero* exposure to illicit drugs. As one commentator put it, cocaine is creating a "bio-underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth."<sup>2</sup> Consequent-

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1. See the Appendix for a list of these women. Most of these cases have not gone to trial, and it is difficult to find accurate information on the exact number and identity of these women. The most widely publicized conviction for the use of illicit substances during pregnancy is that of Jennifer Johnson in Florida. Ms. Johnson was convicted of delivering a cocaine derivative to her two children (born approximately 15 months apart) through her umbilical cord. A lack of evidence that her children were harmed by their *in utero* substance exposure forced the court to find her not guilty of prenatal child abuse. *Florida v. Johnson*, No. E89-890-CFA slip op. (Fla. Cir. Ct., 18th Cir. July 13, 1989), *appeal pending* *Johnson v. Florida*, No. 89-1765 (Fla. Dist. Ct. App., 5th Dist. 1989). Most reports on the Johnson case assert that she is the only woman thus far convicted. See, e.g., N.Y. Times, Feb. 5, 1990, at A14, col. 1; U.S.A. Today, Aug. 25, 1989, at 3A. However, some sources indicate that Johnson is not alone. The A.C.L.U., for example, reports that at least four other women have been convicted of charges including child neglect, delivery of a controlled substance, and criminally negligent homicide. See A.C.L.U. Reproductive Freedom Project, Memorandum: State by State Case Summary of Criminal Prosecutions Against Pregnant Women and Appendix of Public Health and Public Interest Groups Opposed to These Prosecutions (Oct. 29, 1990) and cases cited in the Appendix. One news report stated that in May 1989 an Illinois woman was convicted of prenatal child abuse. L.A. Times, May 27, 1989, § 1, at 23, col. 1.

2. Krauthammer, *Children of Cocaine*, Wash. Post, July 30, 1989, at C7; see also Hentoff, *No 'Rights' to Abuse a Fetus*, Wash. Post, Jan. 19, 1991, at A15, col. 2 (citing irreparable harm to child from maternal use of crack and other substances as rationale for criminal sanction); *Florida v. Johnson*, *supra* note 1,

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ly, prosecutors reason, the only thing standing in the way of solving this tragedy is the refusal of pregnant substance abusers to stop using drugs. By giving these women a reason to seek treatment, they believe, prosecution will solve the problem of substance-exposed children. "Prosecution," explained one prosecutor, "is essential to properly motivate these people."<sup>3</sup>

This Current Topic challenges prosecutors' understanding both of the nature of the problem they confront and of the effectiveness of the solution they propose. Part I explores the assumption that substance exposure, in and of itself, produces inevitable biological harms. It sees the problems of substance-exposed children, not as explainable by one cause, but instead as akin to a Rorschach ink blot into which each of us looks and from which each of us emerges with one coherent interpretation influenced by our background assumptions and our desire for simplicity. Part I first depicts the ink blot, describing the manifold problems associated with drug-exposed babies. Then, it challenges the interpretation prosecutors offer for this crisis. Although *in utero* drug exposure can severely harm these children, it alone fails to account for many, and perhaps even most, of these babies' problems. Instead, these babies owe their problems to various causes, some of which are directly due to substance exposure, some of which are merely associated with drug use, and some of which are completely unrelated to drugs. This conclusion has two ramifications. First, prosecution may be punishing pregnant addicts for behavior we have thus far been unwilling to punish when engaged in by other parents. Second, merely stopping drug abuse during pregnancy will not solve the problems of drug-exposed children.

Part II explores how effective prosecutions are in achieving most prosecutors' stated goal of motivating pregnant substance abusers to enter drug treatment. It suggests that even if *in utero* substance exposure were responsible for all of these babies' problems, prosecutions would still be ineffective for two reasons. First, neither sufficient nor appropriate treatment is available for most pregnant addicts. Second, prosecution actually deters rather than encourages treatment. This Current Topic concludes that comprehensive care—integrating drug treatment, prenatal care, and skills training—offers the only real solution to the problem of drug-exposed infants.

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at 1 ("once the defendant made that choice [to use cocaine] she assumed responsibility for the natural consequences of it. . . . Children, like all persons, have the right to be free from having cocaine introduced into their systems by others.").

3. U.S.A. Today, Aug. 25, 1989, at 3A (statement of Illinois prosecutor Paul Logli, who charged Melanie Green with manslaughter after her newborn died, allegedly as a result of *in utero* exposure to illicit substances).

## I. THE INCORRECT ASSUMPTION OF INEVITABLE BIOLOGICAL EFFECTS

A. *A Rorschach of the Problem*

The past few years have witnessed a nationwide explosion in the number of babies born to mothers who have used controlled substances during pregnancy. Most sources number the total of drug-exposed infants at 375,000 born annually, a nearly four-fold increase since 1985.<sup>4</sup> By the end of the decade there may be as many as 4 million cocaine-exposed babies alone.<sup>5</sup>

The problem of a rapidly growing population of drug-exposed babies extends across the nation. In New York City, for example, the number of babies exposed to illicit drugs *in utero* grew from 802 in 1982 to 3,923 in 1988. The overwhelming majority of this growth is attributable to cocaine use.<sup>6</sup> Florida estimates a four-fold increase in drug-exposed babies just between 1988 and 1989, from 2,512 to approximately 10,000.<sup>7</sup> One hospital in Milwaukee reported that 35% of its 1989 babies were exposed to cocaine in the womb,<sup>8</sup> while a Detroit hospital found that 42.7% of its newborns tested positive for cocaine, heroin, or marijuana.<sup>9</sup> A recent study found almost 9,000 crack babies born in eight cities alone during 1989.<sup>10</sup> These staggering rates of fetal drug exposure led the District of Columbia's Public Health Commissioner to characterize the problem as a public health emergency.<sup>11</sup>

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4. See, e.g., N.Y. Times, Feb. 5, 1990, at A14, col. 1; L.A. Times, Feb. 3, 1990, at A1, col. 5; Newsday, Nov. 6, 1989, at 8. This figure probably derives from a survey of 36 hospitals nationwide which found that 11% of all newborns suffered exposure to a controlled substance at some point during their mothers' pregnancy. See Chasnoff, *Drug Use and Women: Establishing a Standard of Care*, 562 ANN. N.Y. ACAD. SCI. 208, 208-10 (1989).

5. Newsday, Mar. 27, 1990, § 3, at 1, 7, col. 1.

6. Newsday, Dec. 17, 1989, at 3 (city ed.). Figures referring to drug-exposed babies include newborns exposed to all forms of illicit drugs. I will indicate when the statistics include exclusively cocaine babies.

7. L.A. Times, July 31, 1989, § 1, at 1, col. 1.

8. *Missing Links: Coordinating Federal Drug Policy for Women, Infants, and Children: Hearing Before the Senate Comm. on Governmental Affairs*, 101st Cong., 1st Sess. 2 (July 31, 1989) (opening statement of Senator Kohl) [hereinafter *Missing Links*].

9. Chi. Tribune, Oct. 16, 1989, at 1, zone C.

10. N.Y. Times, Mar. 17, 1990, at A8, col. 2. The cities surveyed included New York City (3,837), Los Angeles (2,284), Chicago (1,095), Miami (812), Phoenix (500), San Francisco (360), Tacoma, Wash. (64), and Fort Wayne, Ind. (22).

11. *Missing Links*, *supra* note 8, at 66 (statement of Reed V. Tuckson, M.D., Commissioner of Public Health, District of Columbia). Similar numbers apply in other cities nationwide. During one eight week period 16% of all hospital births in Philadelphia produced drug-exposed babies. *Id.* at 64 (statement of Teresa Hagan, Supervisor of Clinical Services, The Family Center). The 1989 figure for San Francisco is 7%, *id.* at 11 (testimony of Sherry Agnos, Developer of Phoenix Project), and that for cocaine exposure in Milwaukee is between 10% and 15%. *Id.* at 30 (testimony of Howard Fuller, Ph.D., Director, Milwaukee County Department of Health and Human Services). One hospital in Dallas reported a threefold increase, from 65 to 192, in drug-exposed babies between late 1987 and late 1988. A Denver hospital found almost the same increase, from 32 in 1985 to 115 in 1988. *Born Hooked: Confronting the Impact of Prenatal Substance Abuse: Hearing Before the House Select Comm. on Children, Youth, and Families*, 101st Cong., 1st Sess. 5-6 (Apr. 27, 1989) (survey prepared at the request of Rep. George Miller, Chair of Comm.) [hereinafter *Born Hooked*].

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A great deal of evidence has linked the use of controlled substances during pregnancy with potentially devastating effects for the developing fetus and soon-to-be infant. The most feared drug today is cocaine.<sup>12</sup> Cocaine use during pregnancy is associated with urinary tract defects, intrauterine growth retardation, neonatal seizures, retarded neonatal behavioral capabilities, heart deformities, and permanent brain damage.<sup>13</sup>

The detrimental effects of maternal cocaine use begin during the first trimester, when the brain and other organs start to develop. Consequently, even babies born to mothers who did not use cocaine after the first trimester may develop some of the health problems associated with maternal cocaine use.<sup>14</sup> One study, for example, found that women who stopped using cocaine after the first trimester had a rate of *abruptio placentae*<sup>15</sup> similar to women who used cocaine throughout their pregnancy,<sup>16</sup> while another study reported that cocaine use early in the pregnancy put the fetus at high risk for urinary tract deformities.<sup>17</sup> Infants exposed to the drug only during the first trimester also face greater risk of neurobehavioral deficiencies than non-exposed infants.<sup>18</sup>

Cocaine's deforming effects can continue throughout the pregnancy. Use during the third trimester exclusively, for example, can cause a fetus with a

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12. In contrast to usage patterns for all other illicit drugs, which have remained stable or decreased during the past decade, cocaine use in America has increased, particularly among women. Chasnoff, *Newborn Infants with Drug Withdrawal Symptoms*, 9 PEDIATRICS REV. 273, 273 (1988). Moreover, cocaine is the drug most commonly used by pregnant substance abusers. See Cole, *Legal Interventions During Pregnancy*, 264 J. A.M.A. 2663, 2666 (1990); Burkett, Yasin, & Palow, *Perinatal Implications of Cocaine Exposure*, 35 J. REPRODUCTIVE MED. 35, 36 (1990) [hereinafter Burkett]; Ney, Dooley, Keith, Chasnoff, & Socol, *The Prevalence of Substance Abuse in Patients with Suspected Preterm Labor*, 162 AM. J. OBSTETRICS & GYNECOLOGY 1562, 1564 (1990) [hereinafter Ney].

13. See Burkett, *supra* note 12, at 35, 40; Chavez, Mulinare, & Cordero, *Maternal Cocaine Use During Early Pregnancy as a Risk Factor for Congenital Urogenital Anomalies*, 262 J. A.M.A. 795, 797 (1989) [hereinafter Chavez]; Chasnoff, Griffith, MacGregor, Dirkes, & Burns, *Temporal Patterns of Cocaine Use in Pregnancy*, 261 J. A.M.A. 1741, 1744 (1989) [hereinafter Chasnoff, Griffith]. Researchers believe that maternal cocaine use harms the fetus in two ways. First, it restricts the blood flow to the fetus, thus depleting the fetus's oxygen supply. Chasnoff, Griffith, *supra*, at 1744; Zuckerman, Frank, Hingson, Amaro, Levenson, Kayne, Parker, Vinci, Aboagye, Fried, Cabral, Timperi, & Bauchner, *Effects of Maternal Marijuana and Cocaine Use on Fetal Growth*, 320 NEW ENG. J. MED. 762, 766 (1989) [hereinafter Zuckerman]. Second, cocaine passes through the placenta, directly entering the fetus's own circulation. Once in the fetus's system, cocaine lingers there longer than in the mother's because the fetus lacks the enzymes needed to metabolize the drug and because her less-than-fully-developed kidneys and liver delay the drug's excretion once it has been metabolized. Burkett, *supra* note 12, at 41; Chasnoff, *supra* note 12, at 273; Chasnoff, *Cocaine and Pregnancy*, CHILDBIRTH EDUCATOR, Winter 1986/1987, at 37, 38. While cocaine clears from an adult's system in 24 to 48 hours, it may remain with the fetus for 4 to 6 days. Burkett, *supra* note 12, at 41.

14. Chasnoff, Griffith, *supra* note 13, at 1743.

15. A premature separation of the placenta from the womb, which causes hemorrhaging and threatens the lives of both mother and fetus.

16. Chasnoff, Griffith, *supra* note 13, at 1743.

17. Chavez, *supra* note 13, at 798. The same study found no increased risk of genital organ defects. *Id.* at 796.

18. Chasnoff, Griffith, *supra* note 13, at 1744.

normally formed bowel to lose part of her small intestine.<sup>19</sup> In addition, cocaine exposure during the final days of pregnancy can initiate a stroke *in utero*,<sup>20</sup> and may place the neonate at greater risk of premature delivery and low birth weight than if cocaine use had ceased earlier in the pregnancy.<sup>21</sup>

After birth, some of these babies begin to display the consequences of their mothers' substance abuse. Approximately one-third of cocaine-exposed infants are born prematurely and suffer from complications of low birth weight.<sup>22</sup> Many are irritable, constantly tremble, emit high-pitched cries, and do not interact well with others.<sup>23</sup> In addition, babies exposed to cocaine in the womb have a far greater risk of Sudden Infant Death Syndrome than non-exposed babies.<sup>24</sup>

Preliminary studies show that as these children grow, many do not develop normally. At four months, many cocaine-exposed infants still tremble, and their motor development and muscle tone lag behind other babies.<sup>25</sup> One study found that at two years old, babies exposed to cocaine in the womb have smaller than normal heads, interact poorly with others, have shorter attention spans, and are easily distracted.<sup>26</sup>

Finally, as the first of the crack babies enter kindergarten, educators are noting the largest memorable influx of developmentally disabled children into the public schools.<sup>27</sup> These children suffer from "poor abstract reasoning and memory, poor judgment, inability to concentrate, inability to deal with stress, frequent tantrums, a wide variety of behavior disorders, and violent acting out."<sup>28</sup>

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19. *Missing Links*, *supra* note 8, at 35 (testimony of Ira J. Chasnoff, M.D., Director, National Association for Perinatal Addiction, Research and Education).

20. *Id.*

21. Mastrogiannis, DeCavalas, Verma, & Tejani, *Perinatal Outcome After Recent Cocaine Usage*, 76 OBSTETRICS & GYNECOLOGY 8, 9 (1990) [hereinafter Mastrogiannis].

22. Studies have found low birth weight and pre-term delivery in between 20% and 40% of cocaine-exposed babies. *See, e.g.*, Burkett, *supra* note 12, at 37; Keith, MacGregor, Friedell, Rosner, Chasnoff, & Sciarra, *Substance Abuse in Pregnant Women: Recent Experience at the Perinatal Center for Chemical Dependence of Northwestern Memorial Hospital*, 73 OBSTETRICS & GYNECOLOGY 715, 718 (1989) [hereinafter Keith]; Ahmed, Spong, Geringer, Mou, & Maulik, *Prospective Study on Cocaine Use Prior to Delivery*, 262 J. A.M.A. 1880, 1880 (1989); Chouteau, Namerow, & Leppert, *The Effect of Cocaine Abuse on Birth Weight and Gestational Age*, 72 OBSTETRICS & GYNECOLOGY 351, 352 (1988) [hereinafter Chouteau].

23. Burkett, *supra* note 12, at 38; Chasnoff, *supra* note 12, at 273. Researchers are unsure whether drug-exposed infants owe these commonly occurring symptoms to withdrawal or to cocaine's direct effect on their central nervous system. *Id.* at 275.

24. Drug exposure increases an infant's risk of SIDS by a factor of between 5 and 30. *See* Chasnoff, *supra* note 12, at 276 (factor of 5), and Chasnoff, *supra* note 13, at 42 (factor of 30).

25. Chasnoff, *Drug Use in Pregnancy: Parameters of Risk*, 35 PEDIATRIC CLINICS N. AM. 1403, 1407 (1988). These problems can have lasting effects on the child's development. Cocaine-exposed infants' inability to move well, for example, keeps them from exploring their own bodies and thus deprives them of this important means of developing their body image. *Id.*

26. Chi. Tribune, Oct. 16, 1989, at 1, zone C.

27. *Missing Links*, *supra* note 8, at 11 (testimony of Sherry Agnos, Developer of Phoenix Project).

28. Greer, *The Drug Babies*, 56 EXCEPTIONAL CHILDREN 382, 383 (1990).

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Drug-exposed babies also suffer disproportionately from a number of problems that are linked, but not directly attributable, to their exposure to illicit substances in the womb. Among the most serious of these is AIDS. The recent explosion of drug-exposed infants is due partly to two factors. First, women find crack cocaine more attractive than previously available drugs, and women are thus more prevalent in the addict population. While women comprise only one-third of heroin addicts, they account for approximately half of crack addicts.<sup>29</sup> Second, crack use is associated with promiscuous sex, and crack users will do almost anything to obtain the drug, including trading sex for drugs. Cocaine's aphrodisiac qualities reinforce this trend.<sup>30</sup> Given the already high incidence of the HIV virus among the drug-abusing population, this combination cannot help but result in infected babies. Hence, the number of children under five years old contracting and dying from AIDS increased steadily throughout the 1980s. Between 1985 and 1988, the number of deaths from AIDS among that population doubled, while the number of reported cases quadrupled.<sup>31</sup>

A large number of drug-exposed babies fall victim to another problem: child abuse. Crack use seriously impairs the parental instinct.<sup>32</sup> As one researcher explained, substance abuse during pregnancy can hinder mother-child bonding because "[a] woman who feels the anxieties and inadequacies that all new mothers feel, coupled with guilt and worry over her drug abuse during pregnancy, has an extremely difficult time responding to and interacting with a baby who is withdrawn and irritable."<sup>33</sup> "Crack addicts are more susceptible to all stresses in the environment, and children become stressors," another specialist noted.<sup>34</sup> Crack babies' high-pitched crying and difficulty in interacting exacerbate this problem. The result has contributed to a greater than 50% increase in reported cases of child abuse<sup>35</sup> and a 36% rise in child-abuse-related deaths since 1985.<sup>36</sup> Thirty-three percent of child abuse cases in Flori-

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29. Boston Globe, Nov. 1, 1989, at 1, 4. Cocaine may appeal to women more than heroin partly because cocaine, unlike heroin, need not be injected, and thus does not disfigure the user, and because crack cocaine is so cheap. Keith, *supra* note 22, at 715; see also PUBLIC HEALTH SERV., U.S. DEP'T OF HEALTH AND HUMAN SERV., 2 WOMEN'S HEALTH: REPORT OF THE PUBLIC HEALTH SERV. TASK FORCE ON WOMEN'S HEALTH ISSUES IV-9 (1985) [hereinafter WOMEN'S HEALTH] (giving comparative drug use among men and women in the early 1980s).

30. *Missing Links*, *supra* note 8, at 66 (statement of Reed V. Tuckson, M.D., Commissioner of Public Health, District of Columbia).

31. U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES: 1990, at 83, table no. 119; 117, table no. 187 (110th ed. 1990) [hereinafter STATISTICAL ABSTRACT].

32. See N.Y. Times, Mar. 17, 1990, at A8, col. 1.

33. Chasnoff, *supra* note 13, at 42.

34. N.Y. Times, Mar. 17, 1990, at A8, col. 3 (quoting Dr. Elizabeth Rahdert, research psychologist in clinical research at the National Institute on Drug Abuse).

35. STATISTICAL ABSTRACT, *supra* note 31, at 176, table no. 296.

36. See N.Y. Times, Mar. 17, 1990, at A8, col. 1.

da involve substance abuse,<sup>37</sup> while in New York City the figure is about 50%.<sup>38</sup> In total, twenty-two states report substance abuse as the most prominent characteristic in their child abuse and neglect cases.<sup>39</sup>

A related problem is that of "boarder babies," those drug-exposed infants whose mothers abandon them at hospitals after delivery or whose positive tests for drug exposure place them under state custody.<sup>40</sup> Nearly half of eighteen hospitals surveyed in one study reported a problem with "boarder babies."<sup>41</sup> One Miami hospital, for example, reported that it typically had between twenty and thirty "boarder babies" and that the babies remained in the hospital for up to a month after the hospital cleared them for medical discharge.<sup>42</sup>

Together with the previously described abused children, "boarder babies" are surging into the nation's foster care system. In California, for example, nearly 60% of drug-exposed babies are in foster care, and one county, Alameda, reports that drug-exposed children comprise 80% of all of its foster care children under age one.<sup>43</sup> The foster care system, however, is already overburdened, and it is ill-equipped to handle these babies. One Los Angeles pilot program found that its thirteen drug-exposed children had lived in a total of thirty-five foster homes before they reached age three.<sup>44</sup> Substance-exposed

37. *No Place to Call Home: Discarded Children in America: Hearing Before the House Select Comm. on Children, Youth, and Families*, 101st Cong., 1st Sess. 30 (Nov. 1989) [hereinafter *No Place to Call Home*].

38. *Missing Links*, *supra* note 8, at 72 (statement of Ira J. Chasnoff, M.D., Director, National Association for Perinatal Addiction, Research and Education). Since 1985, abuse and neglect referrals have tripled in Milwaukee. *Id.* at 29 (testimony of Howard Fuller, Ph.D., Director, Milwaukee County Department of Health and Human Services).

39. *Id.* at 111 (statement of Mary Sheila Gall, Assistant Secretary for the Office of Human Development Services, Department of Health and Human Services). One Illinois study found that children of substance abusers accounted for nearly half of children removed from their homes because of abuse and neglect. Chasnoff, *supra* note 25, at 1404.

40. A number of states and localities, such as Florida, Los Angeles, and Nassau County, New York, view a positive drug test at birth as evidence of actual or potential abuse or neglect that warrants emergency removal of the child from the mother's custody at birth. During one six-month period in 1988, for example, Nassau County removed 33 babies based on a positive drug test at birth. See Jost, *Do Pregnant Women Lose Legal Rights*, 2 CONG. Q. EDITORIAL RES. REP. 414, 422 (1989); *No Place to Call Home*, *supra* note 37, at 30; *Born Hooked*, *supra* note 11, at 8 (survey prepared at the request of Rep. George Miller, Chair of Comm.); National Law Journal, Oct. 16, 1989, at 1.

41. *Born Hooked*, *supra* note 11, at 8 (survey prepared at the request of Rep. George Miller, Chair of Comm.).

42. *Id.*

43. *No Place to Call Home*, *supra* note 37, at 32 (reporting study of Dr. Neal Halfon, Director, Center for the Vulnerable Child, Oakland, California). The Assistant Secretary for the Department of Health and Human Services' Office of Human Development Services told a Congressional hearing that drug abuse is the biggest problem currently facing the foster care system. *Missing Links*, *supra* note 8, at 52 (testimony of Mary Sheila Gall, Assistant Secretary for the Office of Human Development Services, Department of Health and Human Services). For a further discussion of the foster care system as a model for examining children's health, see Halfon & Klee, *Health and Development Services for Children with Multiple Needs: The Child in Foster Care*, 9 YALE L. & POL'Y REV. 71 (1991).

44. *Parental Substance Abuse and Its Effect on the Fetus and Children: Hearings before the Cal. Select Comm. on Substance Abuse* 30 (Oct. 1988) (testimony of Carol Cole), cited in Moss, *Legal Issues: Drug Testing of Post-Partum Women and Newborns as the Basis for Civil and Criminal Proceedings*, 23 CLEARINGHOUSE REVIEW 1406, 1412 n.51 (1990).

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babies' irritability, incessant crying, and special needs make it difficult to find them foster parents. Milwaukee's Director of Health and Human Services asserts that "[w]e are actually facing the return of orphanages. People don't want to talk about it, but the fact of the matter is that the problem is in long-term care, and you cannot keep shuffling these kids around from foster home to foster home."<sup>45</sup> The District of Columbia's Public Health Commissioner explained to Congress that averting a crisis requires a concerted national effort:

The boarder baby problem is extraordinary, it will require a very real commitment of American people to just simply say that as an American in this day and age the definition of being a civilized patriot cannot be that we would allow babies to live and die in hospitals in these cold and lonely places, but people have to come and adopt them and care for them. And I think that that gives us an opportunity as Americans to express ourselves.<sup>46</sup>

The enormous medical bills, the lost productivity, and the increased burden on the child welfare system all promise to take a tremendous toll on this country's finances. Caring for the drug babies born prematurely this year will cost between \$3 billion and \$5 billion during their first month of life alone.<sup>47</sup> Preparing the children to enter kindergarten will require an additional \$45,000 per infant for health care, social services, and special education.<sup>48</sup> And some studies estimate that prenatal substance exposure has reduced the potential lifetime earnings of just 1989's drug babies by \$10 billion.<sup>49</sup> Finally, learning how best to deal with these children will require funding for research; at present, educators have little idea of how to cope with these children's needs.<sup>50</sup>

These financial costs could prove minimal compared to the unknown social costs these babies may impose on society when they reach maturity. "We must ask the question, what will our nation be like when these physically, emotionally and developmentally damaged children become adults," Howard Fuller, Milwaukee's Director of Health and Human Services testified to a Congressional hearing:

We already have a generation of young people roaming our streets who will kill you just as soon as to look at you. . . . I do not want to face these kids on the street when they get to be 15 and 16, because you are going to be looking at children who have no concept of the value of life. . . . And if we don't do something about this problem now, the problems that we think we have in 1989 are

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45. *Missing Links*, *supra* note 8, at 42 (testimony of Howard Fuller, Ph.D., Director, Milwaukee County Department of Health and Human Services).

46. *Id.* at 10 (statement of Reed V. Tuckson, M.D., Commissioner of Public Health, District of Columbia).

47. *Id.* at 54 (testimony of Elaine M. Johnson, Ph.D., Director of the Office for Substance Abuse Prevention). This figure is based on an average cost of \$30,000 per infant. *Id.* Medicaid will bear much of these costs. *Chi. Tribune*, Oct. 16, 1989, at 1, zone C.

48. *Missing Links*, *supra* note 8, at 2 (opening statement of Senator Kohl).

49. *Id.* at 3.

50. *See Greer*, *supra* note 28, at 382, 383.



going to pale to the problems that we are going to have in the 21st century when these children become adults.<sup>51</sup>

### *B. Interpreting the Rorschach*

Anybody who looks at this portrait of drug-exposed babies has to see a national tragedy, a health and a moral crisis. But there is one flaw with the picture I have just portrayed. Like many reports on this topic, it is selective in what it includes. While it depicts many aspects of this crisis, it discusses only one potential cause: *in utero* exposure to illicit substances. It consequently cannot help but lead the reader to conclude that the biological stamp of illicit substances has produced this tragedy. Again, section A resembles a Rorschach ink blot upon which each of us superimposes our own order and interpretation. The innocence and vulnerability of this tragedy's victims make some want to choose an uncomplicated interpretation that will point to an easily identifiable and remediable cause—like the biological stamp of substance exposure.

A closer scrutiny of the problem, however, soon reveals that this simple interpretation must be qualified significantly. As an initial matter, policy makers must appreciate the limits of current research on this situation. The crack epidemic's recent origin necessarily means that most research is preliminary; researchers insist they do not yet know the exact scope and nature of the problems associated with *in utero* substance exposure.<sup>52</sup> Moreover, a number of factors complicate that research already conducted. Researchers find it difficult to ascertain accurate information about these women's use of illicit substances.<sup>53</sup> The substance abuser's lifestyle makes it difficult to find control groups for experiments.<sup>54</sup> In addition, the mother's individual biochemistry and ability to metabolize cocaine may influence the drug's impact on the fetus.<sup>55</sup>

One thing researchers do know, however, and which is often overlooked in stories on this subject, is that the idea that substance abuse always causes direct biological harm is false. Cocaine use during pregnancy does not inevitably harm the fetus and resulting child. Many children born to women who used drugs during pregnancy seem unaffected by that experience. For example, both

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51. *Missing Links*, *supra* note 8, at 32 (testimony of Howard Fuller, Ph.D., Director, Milwaukee County Department of Health and Human Services).

52. *See, e.g.*, Chavez, *supra* note 13, at 797; Zuckerman, *supra* note 13, at 767; Mastrogiannis, *supra* note 21, at 10; Chasnoff, *supra* note 25, at 1409.

53. Ney, *supra* note 12, at 1565, 1567; Chasnoff, *supra* note 25, at 1405. Women may not fully recount their drug use, and since cocaine only stays in the mother's system for between 24 and 72 hours, urine tests may not reveal all cocaine users. *See* Matera, Warren, Moomjy, Fink, & Fox, *Prevalence of use of Cocaine and Other Substances in an Obstetric Population*, 163 AM. J. OBSTETRICS & GYNECOLOGY 797, 800 (1990) [hereinafter Matera].

54. *See* Keith, *supra* note 22, at 719.

55. *See* Chasnoff, *supra* note 25, at 1404.

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children of Jennifer Johnson, the Florida woman convicted of delivering a controlled substance through her umbilical cord,<sup>56</sup> appear healthy.<sup>57</sup> In fact, the court that convicted Johnson on delivery charges acquitted her of prenatal child abuse because it found insufficient evidence of harm to her children.<sup>58</sup> At most, 40% of drug-exposed babies are born prematurely, apparently the biggest and most costly risk of drug exposure.<sup>59</sup>

Those seeking to solve this crisis must therefore look beyond biological stamping to find the root of many of these children's problems. They must recognize that it is impossible to know whether these babies owe their problems to drug-exposure *per se* or to other factors attendant to their own and their mothers' lives. Many environmental factors, both during pregnancy and after birth, contribute to these children's problems. Drug-addicted women often let their own health deteriorate, and this unhealthiness hampers the fetus's development.<sup>60</sup> An addict's poor nutritional habits, for example, may harm the fetus by preventing the mother from gaining sufficient weight during pregnancy.<sup>61</sup> Substance-abusing women also suffer from a high rate of complications from infectious diseases, particularly sexually transmitted diseases and hepatitis.<sup>62</sup>

Perhaps the most important complicating factor during pregnancy is the impact of the mother's lack of prenatal care on her child's health. Many of the health problems experienced by drug-exposed babies are similar to those already experienced by non-exposed babies whose mothers failed to get prenatal care. For example, babies born to mothers without prenatal care are three times more likely to die within their first year<sup>63</sup> and three to five times

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56. See *supra* note 1.

57. Brief of American Public Health Association and other Concerned Organizations as Amici Curiae in Support of Appellant at 1, *Johnson v. Florida*, *supra* note 1. Lynn Bremer, a Michigan woman similarly charged with delivering drugs to her daughter, also gave birth to an apparently healthy baby. Hoffman, *Pregnant, Addicted—and Guilty?*, N.Y. Times, Aug. 19, 1990, § 6 (Magazine), at 34, 44.

58. See *Florida v. Johnson*, *supra* note 1, at 1; Answer Brief of Appellee at 4 n.3, *Johnson v. Florida*, *supra* note 1.

59. See Ney, *supra* note 12, at 1562 ("The neonatal complications of prematurity are responsible for the majority of adverse perinatal outcomes."). Estimates of the incidence of premature birth range from about 20% to about 40%, depending on many factors, particularly whether the mother received prenatal care. See sources cited *supra* note 22. As discussed *infra*, notes 60-76 and accompanying text, substance exposure is not the only factor contributing to this high rate of premature births.

60. Burkett, *supra* note 12, at 41, 42.

61. See Zuckerman, *supra* note 13, at 766.

62. See Chasnoff, *supra* note 25, at 1406; L. Finnegan, T. Hagan, & K. Kaltenbach, *Scientific Foundation of Clinical Practice: Opiate Use in Pregnant Women* 11 (1990) (unpublished manuscript) [hereinafter Finnegan] (to be published in PREGNANCY AND SUBSTANCE ABUSE: PERSPECTIVE AND DIRECTIONS, PROCEEDINGS OF THE NEW YORK ACADEMY OF MEDICINE (1991)).

63. U.S. DEP'T OF HEALTH, EDUC. & WELFARE, HEALTH PEOPLE: THE SURGEON GENERAL'S REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION (1979), cited in McNulty, *Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses*, 16 N.Y.U. REV. L. & SOC. CHANGE 277, 293 (1987-88).

more likely to suffer from low birth weight<sup>64</sup> than children born to mothers who received adequate care. Yet each year, more than 300,000 American women give birth without adequate prenatal care.<sup>65</sup> While they account for only about 8% of babies born annually, they give birth to two-thirds of all infants who die before their first birthday.<sup>66</sup>

Substance-abusing women are as much as four times less likely than other women to receive prenatal care.<sup>67</sup> Yet prenatal care can significantly improve the health of these women's children.<sup>68</sup> One study found that, compared with substance abusers who lacked prenatal care, cocaine-abusing women who received comprehensive prenatal care gave birth less often to premature and low birth weight babies, and they suffered less frequently from *abruptio placentae*.<sup>69</sup>

Financial barriers provide the primary reason for the lack of prenatal care.<sup>70</sup> Seventeen percent of women of childbearing age have no medical coverage,<sup>71</sup> and about 26% lack insurance to cover prenatal care.<sup>72</sup> Women covered by Medicaid face overburdened and understaffed clinics, and they can find few private doctors willing to treat them.<sup>73</sup> The Department of Defense (DOD) cites its program of free and comprehensive prenatal care as the reason

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64. *Report to the San Diego County Board of Supervisors on the Feasibility of County Indemnification of Community Clinics Providing Prenatal Care* 5 (1986), cited in Memorandum of Points and Authorities in Support of Motion to Dismiss at 8, *California v. Stewart*, No. M508197, slip op. (Cal. Mun. Ct., San Diego, Feb. 26, 1987).

65. N.Y. Times, June 26, 1987, at A1.

66. *Id.*; see also INSTITUTE OF MEDICINE, *PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS* 1 (1988) [hereinafter *PRENATAL CARE*]. Since 1980, the number of women giving birth without adequate prenatal care has been on the increase, particularly for African-American women. 10.3% of African-American women gave birth with late or no prenatal care in 1985, compared to 8.8% in 1980. *Id.* at 1-2. Black women are twice as likely as white women to receive inadequate prenatal care. *Id.* at 3. And prenatal care is becoming less accessible to many poor women. The New York Times reports that since 1980, budget cuts have forced about 1,000 subsidized gynecological clinics to close. N.Y. Times, Mar. 25, 1991, at B1, col. 2.

67. *Born Hooked*, *supra* note 11, at 8 (survey prepared at the request of Rep. George Miller, Chair of Comm.). In Florida, almost 60% of the mothers of substance-exposed children received no prenatal care. *Missing Links*, *supra* note 8, at 86 (statement of Gregory L. Coler, Secretary, Florida Department of Health and Rehabilitation). See also Dixon and Bejar, *Echoencephalographic findings in neonates associated with maternal cocaine and methamphetamine use: Incidence and clinical correlates*, 115 J. PEDIATRICS 770, 772 (1989) (reporting findings that less than one-third of mothers of drug-exposed infants in study received any prenatal care).

68. See MacGregor, Keith, Bachicha, & Chasnoff, *Cocaine Abuse During Pregnancy: Correlation Between Prenatal Care and Perinatal Outcome*, 74 OBSTETRICS & GYNECOLOGY 882, 883 (1989) [hereinafter MacGregor].

69. *Id.* One program of prenatal care reduced the incidence of low birth weight babies among methadone-maintained women from almost 50% to 18%. *Missing Links*, *supra* note 8, at 62 (statement of Terry Hagan, Supervisor of Clinical Services, The Family Center).

70. See generally *PRENATAL CARE* *supra* note 66, at 4-8. Other obstacles include an inadequate supply of services, organizational difficulties, problems in the services themselves, and cultural and personal impediments in the women's backgrounds. *Id.*

71. Gold & Kennedy, *Paying for Maternity Care*, 17 FAMILY PLANNING PERSPECTIVES 103, 105 (1985).

72. *PRENATAL CARE*, *supra* note 66, at 5.

73. Gold and Kennedy, *supra* note 71, at 109; *PRENATAL CARE*, *supra* note 66, at 5.

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why not one baby out of the 100,000 born in its facilities during Fiscal Year 1988 suffered from substance exposure.<sup>74</sup> DOD babies also have a low birth weight rate half that of the general population.<sup>75</sup>

The similarity between some of the problems of substance-exposed babies and of babies born to mothers who received no prenatal care thus makes it impossible to isolate the relative contributions of these two factors. As one study explained, "[o]ne of the difficulties in understanding these relationships [between cocaine use and birth weight and gestational age] is that many cocaine users are urban women of low socioeconomic and minority ethnic status who are already at increased risk for low birth weight and pre-term infants, often because they receive little or no prenatal care."<sup>76</sup>

After the substance-exposed child is born, a number of environmental factors continue to complicate her life. These factors make it difficult to establish whether these babies' problems are the inevitable result of their gestational surroundings or are simply made more probable by the environment in which they will be reared.<sup>77</sup> Children raised by drug-addicted parents are certainly not receiving very good socialization. For example, one study found little difference between the developmental and behavioral patterns of children exposed to illicit substances in their mother's womb and those raised by families who began to use drugs after the child's birth.<sup>78</sup> One researcher posited that the behavioral problems displayed in children of drug-dependent women may partially reflect the mothers' poor parenting skills and inability to set limits on children's behavior.<sup>79</sup> Another study showed that good environmental supports can help infants with brain lesions similar to those in drug-exposed babies overcome the lesions' effects.<sup>80</sup> Most drug-exposed babies, however, will probably not receive these supports.

Instead, drug-damaged families will raise them, and poverty, instability, and violence will pervade their environment. While one study indicates that middle-class white women are just as likely as poor black women to abuse

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74. *Missing Links*, *supra* note 11, at 49-50 (testimony of C. Peter Brock, Director, Alcoholism and Mental Health Programs, Office of the Assistant Secretary of Defense [Health Affairs], Department of Defense).

75. *Id.*

76. Chouteau, *supra* note 22, at 351.

77. *See generally* Chasnoff, *supra* note 25, at 1409; Chasnoff, *supra* note 13, at 42.

78. Chasnoff, *supra* note 25, at 1409. A number of studies have found similar problems in abused children. Compared with non-abused children, abused children suffer from high rates of hyperactivity, are easily distracted, have lower intelligence, and lack self-control. N.Y. Times, Feb. 18, 1991, at A11, col. 4.

79. Finnegan, *supra* note 62, at 22.

80. *See* Newsday, Mar. 27, 1990, § 3, at 1, 7, col. 3. *See also* N.Y. Times, Feb. 7, 1991, at A1, col. 3, D24, col. 1 (reporting study which found that for 60-70% of crack-using women in study, prenatal care, adequate nutrition, and parenting training produced children with no perceptible problems by the age of three or four). The National Association for Perinatal Addiction Research and Education is presently studying adopted cocaine babies to determine the relative contributions of drug exposure and environment on these children's development. Newsday, *supra*.

illicit substances during pregnancy,<sup>81</sup> it is overwhelmingly poor women of color who are the focus of medical studies<sup>82</sup> and press reports, and it is they who are reported to authorities and whom prosecutors charge with using drugs during pregnancy.<sup>83</sup> Yet it is precisely among poor children of color that the biological effects model is most questionable. The present environment of African-American children, for example, is horrendous. They suffer from low birth weight and infant mortality at twice the rate of white American children.<sup>84</sup> Black children constitute nearly 60% of pediatric AIDS cases in which race was identified.<sup>85</sup> Forty-five percent of African-American children live below the poverty level.<sup>86</sup> While African-Americans comprised roughly 12% of the population in 1986,<sup>87</sup> they accounted for 46.9% of the state prison population.<sup>88</sup> Blacks have a lower life expectancy,<sup>89</sup> and black men between the ages of 25 and 34 die at twice the rate of their white counterparts.<sup>90</sup> Black men fall victim to homicides at seven times the rate of white men, while black women's murder rate is fourfold that of white women.<sup>91</sup> As Dr. Fuller's congressional testimony recognized,<sup>92</sup> today's generation of inner-city teenagers already exhibit the behavior feared from tomorrow's crop of crack babies. Given the above statistics, Dr. Fuller's observation is not surprising. Poverty, a crumbling educational system, poor nutrition and health care, the pervasive

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81. Chasnoff, Landress, & Barrett, *The Prevalence of Illicit Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202, 1204 (1990). The study reported therein surveyed hospital compliance with FLA. STAT. ANN. §§ 415.503(1), 415.503(9)(a)(2), .415504 (West 1990), which require hospitals to report pregnant women's positive toxicology tests to health authorities. The study found that while white women were slightly more likely than black women to test positive, at their first visit for prenatal care, for illicit substances or alcohol in their urine (15.4% of white women and 14.1% of black women tested positive), hospitals reported black women to health authorities at ten times the rate of white women. *Id.* The media have frequently cited this study to show similar drug abuse rates across racial lines. See, e.g., The National Law Journal, Oct. 16, 1989, at 1. Broken down by substance, however, cocaine abuse and the consequent problems peculiarly associated with cocaine babies still plague the African-American community at far greater rates than the white American community. The study found that 7.5% of African-American women tested positive for cocaine, in contrast to 1.8% of white women. Chasnoff, Landress, & Barrett, *supra*, at 1204.

82. See, e.g., Chouteau, *supra* note 22, at 352; Burkett, *supra* note 12, at 36; Zuckerman, *supra* note 13, at 767.

83. U.S.A. Today, Feb. 26, 1990, at 3A.

84. STATISTICAL ABSTRACT, *supra* note 31, at 66, table no. 88; 78, table no. 113; see also *supra* note 66, discussing statistics on African-American women's access to prenatal care.

85. Brown, Murphy, and Primm, *The Acquired Immunodeficiency Syndrome: Do Drug Dependence and Ethnicity Share a Common Pathway?*, in NATIONAL INSTITUTE ON DRUG ABUSE, PROBLEMS OF DRUG DEPENDENCE, 1987: PROCEEDINGS OF THE 49TH ANNUAL SCIENTIFIC MEETING, THE COMMITTEE ON PROBLEMS OF DRUG DEPENDENCE, INC. 188, 189 (NIDA Research Monograph 81 1988). Latino children provided another 22% of the cases. *Id.*

86. STATISTICAL ABSTRACT, *supra* note 31, at 460, table no. 745. In contrast, 15% of white American children live in poverty. *Id.*

87. *Id.* at 12, table no. 11.

88. *Id.* at 187, table no. 323.

89. *Id.* at 72, table no. 103.

90. *Id.* at 75, table no. 108.

91. *Id.* at 173, table no. 288.

92. See *supra* note 51 and accompanying text.

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presence of crime, and the hopelessness that result from living in such an environment—all of these factors contribute to the behavior currently observed in inner-city children and feared in the future from substance-exposed children.<sup>93</sup>

The plight of substance-exposed children is thus far more complex than prosecutors' biological stamping model indicates. Rather than owing their problems exclusively to *in utero* substance exposure, these babies have to blame a complex interrelationship of many factors in addition to substance exposure: their mothers' health during pregnancy, the way they are reared, and the greater environment in which they live. Few would dispute that society should not hold pregnant substance abusers responsible for the effects on their children of either an environment beyond their control or their financial inability to obtain proper health or prenatal care. Some, however, might assert that if drugs cause women not to take care of themselves or to be bad parents, then we can punish them for that. But we should not allow such an argument's initial appeal to make us forget how inconsistent prosecutions would then be with our society's current state of legal liability.

Our society has always placed a high value on individual autonomy—on allowing each person to make certain choices for herself. Those advocating prosecution assert that we need not worry about infringing drug addicts' liberty interests in using drugs, because no one has a right to use drugs.<sup>94</sup> But choosing what to eat or when to see a doctor are decisions of a qualitatively different nature. We should not force women to give up the right to make these choices merely because they have also chosen to use drugs—an act for which the law already provides a penalty.

Still, many would assert, the unique status of pregnancy allows us to impose these restrictions on women. But the evidence as to the effect of environment on the born child requires us to question whether substance-abusing mothers damage their children not via the unique circulatory bond of pregnancy, but rather through the more common relationship of parent and child. These mothers may be unable to raise their children well not because of what drugs do to their fetuses, but because of what drugs do to the women as social beings. In effect, using drugs makes the substance abuser a bad parent, one who is incapable of both supporting and setting limits for her child.

Our society could choose to criminalize bad parenting, to make that moral wrong a legal one. Up to now, however, that is not a decision we have been

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93. See N.Y. Times, Feb. 21, 1991, at B9, col. 3 (describing studies on detrimental effects of growing up in a violent environment). For a picture of how these statistics affect one inner-city child's life, see N.Y. Times, Oct. 9, 1990, at A1, col. 2.

94. See, e.g., Curriden, *Holding Mom Accountable*, 76 A.B.A. J. 50, 53 (1990) (quoting one proponent of prosecuting those women unwilling to undergo drug treatment as saying that "no woman, whether she's pregnant or not, has the right to use cocaine. In this area, I think it's fairly clear we're not interfering with somebody's legal rights").

willing to make. Again, Dr. Fuller's comment about the behavior of inner-city teenagers well captures the tremendous problems of the present generation of urban youth, harmed by a lack of access to prenatal care or by poverty and violence. Yet no one is crying out to prosecute these children's parents or those responsible for the turmoil in our inner cities.

A comparison with the way we treat other parental behavior reveals that prosecution, shorn of its simplistic biological stamping rationale, may be imposing unequal responsibilities on women and men. For example, condemnation of maternal substance abuse is no doubt influenced by the explosion of "boarder babies" and the impending collapse of the foster care system. But what differentiates these women's actions in leaving their babies from those of men, who for years have abandoned their children to be raised by their mothers alone? Why do we see "boarder babies" as a result of maternal substance abuse and fail even to ask where these infant's fathers are? Is prosecution of maternal substance abusers a sign that we are unwilling to accept this commonly accepted male behavior from women? Consider too the effects of a father's absence, both in dooming his child to a life of poverty and on his child's social development. No one has suggested prosecuting such men for not giving their children role models or emotional support. Finally, consider the parents of the women we now want to prosecute. One study, for example, has shown that 70% of female substance abusers had at least one substance abusing parent.<sup>95</sup> Again, no voices are heard advocating the prosecution of these parents, the effects of whose substance abuse so completely pervaded the future lives of their daughters. Proponents of prosecution try to distinguish these examples by reference to substance exposure's direct biological effects. The above data, however, show that this view is much too simplistic, and that in the majority of cases, there is probably no direct and inevitable biological predetermination.<sup>96</sup>

In sum, prosecutors have tremendously exaggerated the effects of *in utero* exposure to illicit substances and underestimated the contribution of other factors to these children's problems. This means that what we may, in fact, be prosecuting these women for is just plain bad parenting, or even more troubling, the misfortune of being poor. I do not doubt that these women are morally culpable for many of the harms suffered by their children. But making

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95. I elaborate further on this study in Part II, *infra*, notes 117-20 and accompanying text.

96. This response by prosecutors also ignores evidence that male drug use can harm men's sperm and their offspring. See Cohen, *Paternal Contributions to Birth Defects*, 21 NURSING CLINICS N. AM. 49, 58 (1986) (reporting animal studies showing that male narcotic use results in "decreased birth weight, small litter sizes, increased prenatal losses, increased stillbirth rates, and decreased neonatal survival . . ."). Prosecutors would probably assert that such male behavior is far less likely to harm children than corresponding female behavior, but, as I have shown, such *in utero* exposure, in and of itself, is far less likely to harm children than prosecutors assume.

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them legally responsible for this moral failure would be inconsistent with the way we generally behave toward parents.

Perhaps more important for those trying to design a policy to deal with this problem, the realization that the problems of substance-exposed children have many causes means that simply requiring the mother to abstain from drug use during pregnancy's nine months will not shield the child from harm. Unless the pregnant woman has increased access both to health care for herself and to prenatal care for her child, she may still give birth to a damaged child. And once the child is born, raising her in a drug-damaged family or an impoverished environment may mitigate any positive benefits of a drug-free pregnancy. While stopping maternal substance abuse may prevent some suffering, it alone far from guarantees that these children will turn out healthy, particularly if the only change in the mother's situation is that she refrains from using drugs during her pregnancy. Any policy maker must include these realizations in her policy-making calculus.

## II. THE INEFFECTIVENESS OF PROSECUTION

Properly evaluating a policy option requires not just an understanding of the problem it aims to solve, but also a clear articulation of the policy's goal and an examination of the effects the policy will have if implemented. The discussion in Part I shows that prosecutors do not appreciate the complexity of the problems of substance-exposed children and, consequently that addressing what they see as the cause of this crisis would not solve these children's problems. Yet even if the prosecutors' model of biological stamping were correct, their proposed solution still would not succeed.

Proponents of criminalizing maternal substance abuse assert that they are not seeking retribution against the women they prosecute. Instead, they claim, they are trying to help the women and their babies. "Our main concern is to send a message to drug abusers that they should seek treatment before the criminal justice system has to become involved," explained one Michigan prosecutor.<sup>97</sup> An Illinois lawmaker expressed similar sentiments after a grand jury refused to indict one maternal substance abuser: "It is not easy to enforce morality with some people but people have to be made to take responsibility. Why don't these women get help?"<sup>98</sup>

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97. Detroit Free Press, Oct. 28, 1989, at 1A (statement of Tony Tague, prosecutor of Kimberly Hardy and Lynn Bremer).

98. Boston Globe, Oct. 3, 1989, at 1 (statement of Illinois State Senator Richard Kelly after grand jury refused to indict Melanie Green).



*A. The Insufficiency and Inappropriateness of Current Treatment Options for Pregnant Addicts*

Unfortunately, these prosecutors' views do not comport with reality. Sending messages to pregnant drug users to get treatment will not work because, as the experiences of many of the prosecuted women demonstrate, there is very little treatment available to them. The attempts of Jennifer Johnson, a Florida woman convicted of delivering cocaine to her children,<sup>99</sup> to get treatment, for example, proved helpful only to her prosecutors; they used the resulting paper trail as evidence of her addiction.<sup>100</sup> And the efforts of Melanie Green, an Illinois woman charged with manslaughter after her allegedly substance-exposed newborn died,<sup>101</sup> to enter the only inpatient drug treatment program in her home town proved fruitless; the program had a six-month waiting list.<sup>102</sup>

Treatment opportunities are limited for all drug users. At the time of her arrest, for example, Jennifer Johnson's home state had more than 2,000 people waiting for treatment. More than 600 could not receive treatment within a reasonable time.<sup>103</sup> Pregnant drug users, however, face a more acute shortage of treatment facilities than any other segment of the population. One study of New York City treatment programs showed that 54% completely excluded pregnant women, 67% would not accept pregnant women on Medicaid, and 87% refused to treat pregnant crack addicts on Medicaid. In addition, not even half of the programs that did admit pregnant women offered prenatal care, and only two programs provided day care for the women's children.<sup>104</sup>

Pregnant women face equally bleak prospects for treatment in other cities. One survey of 18 hospitals nationwide found that two-thirds of hospitals had no place to refer pregnant women for treatment.<sup>105</sup> Boston has only about 30 residential treatment slots available for pregnant cocaine addicts.<sup>106</sup> Only

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99. For a discussion of the Johnson case, see *supra* note 1.

100. Johnson called for an ambulance several times during her pregnancy, out of concern for her baby. "I thought that . . . if I tell 'em I use drugs they would send me to . . . a drug place or something," she stated at trial. Appellant's Initial Brief at 4, *Johnson v. Florida*, *supra* note 1. The state introduced the report of one of Johnson's calls into evidence at trial as proof of Johnson's cocaine use during pregnancy. Answer Brief of Appellee at 5, *Johnson v. Florida*, *supra* note 1.

101. *Illinois v. Green*, No. 88-CM-8256 (Cir. Ct. filed May 8, 1989); see also *N.Y. Times*, May 27, 1989, at A19, col. 5.

102. *Boston Globe*, Oct. 3, 1989, at 1; see also Jost, *supra* note 40, at 422 (waiting list had 77 names).

103. *Missing Links*, *supra* note 8, at 82 (statement of Gregory L. Coler, Secretary, Florida Department of Health and Rehabilitation).

104. *Born Hooked*, *supra* note 11, at 112 (statement of Wendy Chavkin, M.D.). Chavkin surveyed 78 programs, 95% of the total available in New York City. In late 1989 the A.C.L.U. filed a lawsuit on behalf of New York women unable to find drug treatment. *Elaine W. et al. v. North General, et. al.*, No. 6230-90 (N.Y. Sup. Ct. filed Nov. 23, 1989).

105. *Born Hooked*, *supra* note 11, at 8 (survey prepared at the request of Rep. George Miller, Chair of Comm.).

106. *Id.*

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67 of California's 366 publicly funded programs have space for women, and only 16 of these make provisions for their clients' children.<sup>107</sup> One California residential program for pregnant addicts has 60 women waiting for its 6 beds.<sup>108</sup> Although San Francisco had 700 drug-exposed babies in 1989, it began to develop its first residential treatment center for pregnant women only late that year, and the center will accommodate only 15 women at a time.<sup>109</sup>

Many factors account for the dearth of treatment programs for pregnant women, most of which derive from a legacy of discrimination against female addicts. Most research in the field has been conducted on men, purportedly because men comprised the majority of substance abusers and because researchers feared conducting research that might potentially harm women's reproductive systems.<sup>110</sup> Consequently, almost all traditional treatment models were designed with male substance abusers in mind. This means not only that there is not enough treatment available, but also that what does exist is largely inappropriate to meet the needs of female, and particularly pregnant, substance abusers.

Studies on substance-addicted women have found a number of characteristics that distinguish women addicts from their male counterparts.<sup>111</sup> First, the health of women addicts is generally poorer than men's, due in no small part to the women's relative poverty and consequent inability to pay for health care.<sup>112</sup> Second, women are more likely to lack education and marketable

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107. Boston Globe, Nov. 1, 1989, at 1, 4.

108. *Missing Links*, *supra* note 8, at 18-19 (testimony of Minnie Thomas, Director of Mandella House).

109. *Id.* at 11, 18 (testimony of Sherry Agnos, Developer of Phoenix Project). While women account for about one-half of all crack addicts, they comprise less than one-third of those entering publicly funded treatment. Boston Globe, Nov. 1, 1989, at 1, 4.

110. WOMEN'S HEALTH, *supra* note 29, at IV-9, -49; *see also* Unger, *Chemical Dependency in Women: Meeting the Challenges of Accurate Diagnosis and Effective Treatment*, 149 W. J. MED. 746, 746 (1988); Vourakis, *Women in Substance Abuse Treatment*, in G. BENNETT, C. VOURAKIS, AND D. WOOLF, *SUBSTANCE ABUSE: PHARMACOLOGIC, DEVELOPMENTAL, AND CLINICAL PERSPECTIVES* 382, 382, 386 (1983); studies cited in Means, Small, D. Capone, T. Capone, Condren, Peterson, and Hayward, *Client Demographics and Outcome in Outpatient Cocaine Treatment*, 24 INT'L J. ADDICTIONS 765, 768-69 (subjects in five studies on cocaine abuse ranged from 63.3% male to 82% male). Means et. al. also point to class bias in research on cocaine addicts. Most of the studies they surveyed focused on middle- and upper-middle class subjects, who probably represent neither the characteristics nor the problems of much of the cocaine-abusing population. *Id.* at 779. Discrimination in medical research is not limited to the field of substance abuse. Male-only studies predominate in a large variety of health care areas. *See* Ames, *Our Bodies, Their Selves*, NEWSWEEK, Dec. 17, 1990, at 60; Leary, *Inquiry Sought on Drug Tests That Exclude Women*, N.Y. Times, Feb. 28, 1991 at A23, col. 1; *see also* Hamilton, *Guidelines for Avoiding Methodological and Policy-Making Biases in Gender-Related Health Research*, in WOMEN'S HEALTH, *supra* note 29, at IV-53-64.

111. *See generally* WOMEN'S HEALTH, *supra* note 29, at IV-12-14; Unger, *supra* note 110, at 747; Stevens, Arbiter, and Glider, *Women Residents: Expanding Their Role to Increase Treatment Effectiveness in Substance Abuse Programs*, 24 INT'L J. ADDICTIONS 425, 426-27 (1989).

112. *See* WOMEN'S HEALTH, *supra* note 29, at IV-12, -49; Unger, *supra* note 110, at 748. Nearly 80% of America's poor are women and children. *Id.* at I-12. Women's smaller economic resources also limit available treatment options. *See* Beckman and Amaro, *Patterns of Women's Use of Alcohol Treatment Agencies*, ALCOHOL HEALTH & RES. WORLD, Winter 1984/85, at 15, 18.

job skills.<sup>113</sup> By making it more difficult for women to become self-supportive, this skills gap can hamper rehabilitation. Third, addicted women generally receive less emotional and social support. The director of one residential rehabilitation program for female addicts, for example, reported that nine out of ten men leave addicted women, while only one in ten women leave their addicted mates.<sup>114</sup> Studies of alcoholics report that women not only receive less encouragement to enter treatment, but also that they are likely to face active opposition to such a move.<sup>115</sup> Fourth, women addicts, as well as society, perceive themselves as more socially deviant than male abusers, and they are more likely to feel trapped in their hopeless conditions.<sup>116</sup>

A study conducted by a treatment center for women addicts further illuminates the correlation between personal background and substance abuse among women.<sup>117</sup> The study compared two dozen female substance abusers with non-abusers from similar socioeconomic backgrounds. Among the drug-abusing women, almost 70% had been sexually abused (three-fourths by the time they reached their sixteenth birthday), and over 70% had at least one chemically dependent parent. In comparison, just 15% of non-dependent women experienced sexual abuse, and only 35% reported a substance-abusing parent.<sup>118</sup> In addition, while growing up, drug-dependent women suffered more physical violence and family conflict, and they had less cohesive families than non-abusers.<sup>119</sup> Finally, the drug-addicted group revealed the effects of their childhood environment on their self-esteem when all but one of them responded affirmatively to the question "when you were growing up, did you wish you were someone else?" Only 30% of the non-dependent group gave that response.<sup>120</sup>

Apart from these physical and psychological differences, many addicted women have another special problem that traditional treatment methods have

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113. See WOMEN'S HEALTH, *supra* note 29, at IV-50. See also Weiss, Lange, Mirin, and Griffin, *Sex Differences in Hospitalized Cocaine Abusers*, in NATIONAL INSTITUTE ON DRUG ABUSE, PROBLEMS OF DRUG DEPENDENCE, 1988: PROCEEDINGS OF THE 50TH ANNUAL SCIENTIFIC MEETING, THE COMMITTEE ON PROBLEMS OF DRUG DEPENDENCE, INC. 363, 363 (NIDA Research Monograph 90 1988); Unger, *supra* note 110, at 747.

114. N.Y. Times, Mar. 17, 1990, at A8, col. 1.

115. WOMEN'S HEALTH, *supra* note 29, at IV-47.

116. See *id.* at IV-12, -13, -44; Vourakis, *supra* note 110, at 387.

117. Hagan, *A Retrospective Search for the Etiology of Drug Abuse: A Background Comparison of a Drug-Addicted Population of Women and a Control Group of Non-Addicted Women*, in NATIONAL INSTITUTE ON DRUG ABUSE, PROBLEMS OF DRUG DEPENDENCE, 1987: PROCEEDINGS OF THE 49TH ANNUAL SCIENTIFIC MEETING, THE COMMITTEE ON PROBLEMS OF DRUG DEPENDENCE, INC. 254 (NIDA Research Monograph 81, 1988).

118. *Id.* at 258-59. One fourth of the chemically dependent women were raped by a father, grandfather, or brother. *Id.* Other studies have found similarly high rates of sexual abuse among women drug addicts. See Stevens, Arbiter, and Glider, *supra* note 111, at 427.

119. Hagan, *supra* note 117, at 260.

120. *Id.* at 259.

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overlooked: children.<sup>121</sup> Most pregnant addicts have other children. Children provide additional stress in the women's lives, and this stress can both thwart the treatment's effectiveness and make relapse more likely. Children also impede women's ability to attend treatment. Without provisions for child care, women face the choice of missing treatment appointments or, if permissible, bringing the children along and having the children's boredom and irritability interfere with treatment's effectiveness.<sup>122</sup> One study calls child care services "the linchpin without which treatment participation is impossible."<sup>123</sup>

Women substance abusers thus have a set of problems that traditional drug treatment models do not contemplate. The presence of other children, women's different physical and psychological problems, and the complications of pregnancy instead require maternal substance abusers to confront three separate systems: health care, drug treatment, and child protection. The lack of communication and coordination among these branches means that no one is looking comprehensively at these women's problems. "One of the most striking public health policy problems is the complete inadequacy of our current approaches to service delivery," the director of the Office for Substance Abuse Prevention testified to Congress.<sup>124</sup> This situation breeds great discouragement among clients and proves harmful to both clients and their children. It disaggregates the different parts of the addict's personality and life, and thereby the causes of her problems. While treatment for men may also suffer from this flaw, it takes on greater urgency with the pregnant addict. She must grapple not only with her addiction, but also with her health, with her fetus's health, and often with supporting and rearing a family. The Director of the Defense Department's Alcoholism and Mental Health Programs attributes part of the Defense Department's success in preventing substance-exposed babies among their personnel<sup>125</sup> to the Coordinated Family Advocacy Program. That program enables one person to evaluate fully each client's problem, design a comprehensive treatment plan, and serve as the client's advocate in dealing with all aspects of the bureaucracy.<sup>126</sup>

The insufficiency and inappropriateness of current treatment for pregnant women is made particularly unfortunate by the fact that pregnancy is an op-

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121. Brief of American Public Health Association and other Concerned Organizations as Amici Curiae in Support of Appellant at 5, *Johnson v. Florida*, *supra* note 1.

122. Finnegan, *supra* note 62, at 23. Some women, under court pressure to enter residential treatment programs, have even had to place their children in foster homes. They later faced lengthy legal battles to regain their children. Stevens, Arbiter, and Glider, *supra* note 111, at 428.

123. *WOMEN'S HEALTH*, *supra* note 29, at IV-49.

124. *Missing Links*, *supra* note 8, at 46 (testimony of Elaine M. Johnson, Ph.D., Director of the Office for Substance Abuse Prevention); *see also id.* at 37 (testimony of Howard Fuller, Ph.D., Director, Milwaukee County Department of Health and Human Services).

125. *See supra* notes 74-75 and accompanying text.

126. *Missing Links*, *supra* note 8, at 53 (testimony of C. Peter Brock, Director, Alcoholism and Mental Health Programs, Office of the Assistant Secretary of Defense [Health Affairs], Department of Defense).

timal time to motivate women to stop using drugs.<sup>127</sup> Jennifer Johnson and Melanie Green both tried, without success, to enter treatment programs during their pregnancies.<sup>128</sup> One telephone hotline for pregnant addicts, serving seven midwestern states, received 2,700 calls during its first two years in operation.<sup>129</sup>

Society would thus be well served by offering pregnant addicts integrated, holistic, and comprehensive approaches to treatment. Such treatment includes not only drug treatment and prenatal care, but also what Minnie Thomas, the director Mandella House, a model residential program in Oakland, California, calls "reality treatment." Her program teaches women how to manage their time, how to stay on a schedule, and how to care for their children:

Reality treatment means that if you are going to hold down a full-time job, you need to be programmed in that way. That means get up at 6 o'clock in the morning. You have got certain things to do. You have got your breakfast to fix and your house to clean and baby to clean and you are ready to go at a certain time.<sup>130</sup>

Thomas's program treats six women and their infants at a time. They stay in the House between 12 and 18 months and may not leave unaccompanied by a staff member during their first six months in residence, because of the omnipresence of drug dealers and other temptations. The women study six hours each day. In addition, the program provides them with a social support network once they complete their in-patient treatment. Mandella House has a 75% to 80% success rate, costs about \$100 per person per day, and has a sixty-woman waiting list.<sup>131</sup>

Other programs offering comprehensive care have similar success rates. One Chicago out-patient program makes available medical and psycho-therapeutic care to its pregnant clients. It has found that 79% of its patients remain in treatment one year after they gave birth.<sup>132</sup> Amity, Inc., a residential treat-

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127. See Rosenbaum and Murphy, *Women and Addiction: Process, Treatment and Outcome*, in NATIONAL INSTITUTE ON DRUG ABUSE, THE COLLECTION AND INTERPRETATION OF DATA FROM HIDDEN POPULATIONS 123 (NIDA Research Monograph 98, 1990).

128. See *supra* notes 99-102 and accompanying text.

129. *Missing Links*, *supra* note 8, at 38 (testimony of Ira J. Chasnoff, M.D., Director, National Association for Perinatal Addiction, Research and Education). In one Northern California town, public outcry succeeded in averting criminal charges against a pregnant heroin addict who had driven 120 miles each day for several months to the methadone program nearest to her home town. *National Law Journal*, Oct. 16, 1989, at 1.

130. *Missing Links*, *supra* note 8, at 13 (testimony of Minnie Thomas, Director of Mandella House).

131. *Id.* at 13-14, 18-19, 25. As of last year, the United States had only about 21 residential programs capable of accommodating women and their children. These programs can serve between 500 and 1,000 families annually. *N.Y. Times*, Mar. 17, 1990, at A8, col. 5.

132. *Missing Links*, *supra* note 8, at 38 (testimony of Ira J. Chasnoff, M.D., Director, National Association for Perinatal Addiction, Research and Education). The same agency runs another innovative program, the Cocaine Baby Help Line. As mentioned *supra* note 129 and accompanying text, during its first two years in operation this professionally-staffed hotline received 2,700 calls from women seeking information and referrals. As the hotline gained more publicity, the average point during pregnancy at which women phoned fell from twenty-eight weeks to twelve weeks. *Id.*

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ment center in Tucson, Arizona, found that treatment outcomes for both male and female residents improved when the program instituted reforms aimed at helping women residents—for instance child care, parenting training, medical care, and job counseling.<sup>133</sup> These reforms nearly doubled the average length of stay of women residents and increased the time in residence of men by one-third.<sup>134</sup>

While fully funding such programs may seem expensive, successful treatment costs just a fraction of failure. The developer of one model residential treatment program estimates that her program will cost between \$50 and \$70 per woman per day.<sup>135</sup> In contrast, foster care costs more than \$90 per day, and a stay in an intensive care unit costs about \$1500 per day.<sup>136</sup> A specialist in the field estimated that the annual national cost of the lack of treatment options for pregnant addicts exceeds \$3 billion.<sup>137</sup>

### *B. The Harmful Side Effects of Prosecution*

The lack of available treatment makes it doubtful that prosecuting maternal substance abusers is a useful way to achieve prosecutors' stated goal of encouraging women to seek treatment. In fact, prosecutors may be undercutting their own goal by deterring women from seeking what prenatal care and drug treatment is available to them. One health care worker reported such effects after the arrest of Pamela Stewart in California:<sup>138</sup>

I talk on the phone to two to three women per week and see on average of three to four women per week . . . . Since the filing of *People v. Pamela Stewart*, women have constantly expressed concerns to me that I would turn them in. This prosecution has severely and negatively impacted my client-therapist relationships. . . . [A]s a result of this prosecution, clients will stop being honest with us or not show up for help at all. . . . I believe this prosecution is driving women away from what they need.<sup>139</sup>

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133. Stevens, Arbiter, and Glider, *supra* note 111, at 428-33.

134. *Id.* at 431-32. Studies have found that the length in time in treatment is one of the best predictors of treatment success. R. HUBBARD, M. MARSDEN, J. RACHAL, H. HARWOOD, E. CAVENAUGH, H. GINZBURG, *DRUG ABUSE TREATMENT: A NATIONAL STUDY OF EFFECTIVENESS* 94 (1989).

135. *Missing Links*, *supra* note 8, at 12 (testimony of Sherry Agnos, Developer of Phoenix Project).

136. *Id.* As discussed *supra* note 131 and accompanying text, Mandella House's director estimates that her program costs \$100 per person per day and has a 75% to 80% success rate. *Id.* at 25 (testimony of Minnie Thomas, Director of Mandella House).

137. *Id.* at 75 (statement of Ira J. Chasnoff, M.D., Director, National Association for Perinatal Addiction, Research and Education). Dr. Chasnoff arrived at this figure by comparing a \$5000 drug treatment bill to the \$31,000 charge for a twenty-day stay at an I.C.U. required for each of the approximately one-third of drug-exposed babies in need of such hospitalization. *See also* *PRENATAL CARE*, *supra* note 66, at 18 (reporting an Institute of Medicine study that found that each dollar spent on prenatal care for poor women saved over \$3.00 in medical care for their low birth weight babies during the babies' first year of life).

138. *California v. Stewart*, *supra* note 64 (court dismissed charges of failure to provide for minor child because legislature did not contemplate statute imposing duty of care on pregnant women).

139. Declaration of Cathy Hauer, M.S., at 2, 3, Appendix to Defendant's Demurrer without Leave to Amend and/or Motion to Dismiss, *California v. Stewart*, *supra* note 64.

The director of the Cocaine Baby Help Line in Illinois reported similar responses after the prosecution of Melanie Green:

as that hit the media we had literally hundreds of calls from women who said, I followed your advice, I talked to my obstetrician, told him I was using, but now are you going to take my baby away from me? Am I going to be charged? And if so, then I am going to change obstetricians and I am not going to tell him about my drug use.<sup>140</sup>

Jennifer Johnson's experience is instructive for those who question these women's fears. Johnson expressed fear about her addiction's effect on the child she was carrying to paramedics, to the doctor who delivered her child, and to child protection workers. The state introduced these conversations at trial as proof of Johnson's cocaine addiction.<sup>141</sup> Moreover, her prosecutors claimed that Johnson waived her constitutional right to privacy when she called paramedics to help her and her baby.<sup>142</sup>

Prosecution may further harm the health of pregnant substance abusers and their children by disrupting the relationship between these women and their medical caretakers. Doctors will not want to report these women, yet will fear breaking the law if they knowingly fail to report substance-abusing patients. Fear of the criminal sanction may thus lead medical workers to avoid identifying pregnant substance abusers. This will not only hamper treatment of the individual addict, but will also stifle data and research collection.<sup>143</sup>

The prospect of sending these women to jail places their future children at risk for additional health problems. While prosecutors assert that they do not aim to punish these women, the present paucity of treatment options makes it likely that these prosecutions will send some women to jail.<sup>144</sup> Not only will these women still have access to illicit substances in jail, but they will also have little chance of receiving proper prenatal care, adequate nutrition, or drug treatment, thus compounding the harm to their fetuses.<sup>145</sup> One study of three

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140. *Missing Links*, *supra* note 8, at 39 (testimony of Ira J. Chasnoff, M.D., Director, National Association for Perinatal Addiction, Research and Education).

141. Answer Brief of Appellee at 5, 6, 7, 25, *Johnson v. Florida*, *supra* note 1.

142. Answer Brief of Appellee at 39, *Johnson v. Florida*, *supra* note 1. For Johnson's account of the statement constituting the alleged waiver, see *supra* note 100.

143. See *Missing Links*, *supra* note 8, at 86-87 (statement of Gregory L. Coler, Secretary, Florida Department of Health and Rehabilitative Services).

144. A number of proponents of criminalizing maternal substance abuse assert that they do not wish to punish the women and instead propose to put these women in a place where they have all liberties except that of using drugs. See, e.g., Krauthammer, *supra* note 2. However, these commentators offer only euphemisms for jail. At present, American society has few places capable of ensuring women all liberties except that of using controlled substances.

145. Barry, *Pregnant Prisoners*, 12 HARV. WOMEN'S L.J. 189, 189-90 (1989). For a description of conditions inside one women's prison, see Priest, *Jammed up at the Jail: Crowding Strains Life in Arlington Facility*, Wash. Post, Apr. 1, 1990, at A1.

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prisons, for example, found that fewer than half of pregnant prisoners gave birth to live babies.<sup>146</sup>

Prosecution as a policy possesses one final flaw: it fails to account for what will happen to the children if their mothers go to jail or are otherwise incarcerated. Many pregnant substance abusers already have one or more children. As discussed earlier,<sup>147</sup> the foster care system is already overburdened and not well-equipped to cope with substance-exposed children. While many of these women may not be fit mothers, with treatment most of them will probably do better with their children than will the foster care system.

The lack of drug treatment, prosecution's deterrent effects, and the harmful consequences of sending women to jail all militate against choosing prosecution as a policy option if the goal is to get pregnant addicts into treatment. It is, of course, unlikely that comprehensive and freely available prenatal care and drug treatment can entirely solve the problem of drug-exposed babies. Ridding oneself of an addiction is an incredibly difficult task, and it is not one that all drug-addicted women will be prepared to undertake.<sup>148</sup> The population of pregnant addicts is certainly a diverse one, and while the majority of these women may opt for treatment if it is available, some may not.

However, recognizing that non-punitive solutions will not entirely solve the problem does not undermine the overwhelming evidence that prosecution will be counter-productive. The experiences of programs that do treat pregnant addicts and the apparent desire of many of these women to reform themselves indicate that sufficient and appropriate treatment will go a long way toward solving that problem. Given those experiences and evidence that fear of prosecution deters addicts from seeking prenatal care and drug treatment, we must decide whether to adopt a policy that will help the most women and babies or whether to structure a policy around the feared recalcitrant few of the future, and thereby risk losing those who would voluntarily enter treatment and rehabilitate themselves. If what we wish to do is help as many women and children as possible, the choice is obvious.

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146. Barry, *Quality of Prenatal Care for Incarcerated Women Challenged*, 6 YOUTH L. NEWS 1, 2-3 (Nov.-Dec. 1985) Barry cites a number of examples of how inadequate care caused pregnant prisoners to lose their babies: "Linda B. had already lost her first child in labor and her second pregnancy resulted in miscarriage; although she was more than eight months pregnant and had been at the prison for almost five months, she had not *once* been seen by an obstetrician. . . . Marlena S. had gained over 100 pounds by her eighth month of pregnancy and had protein in her urine; in spite of critical high risk factors she had only been seen twice at the high risk OB/GYN clinic in the outside hospital; prison officials flatly refused to issue her a special diet, as recommended by the OB clinic." *Id.* at 3 (emphasis supplied).

147. *Supra* notes 43-46 and accompanying text.

148. See Keith, *supra* note 22, at 719. Overcoming a cocaine addiction is particularly difficult because, unlike heroin, cocaine has no methadone analog to relieve the physical pain of withdrawal. *Id.* See also Cole, *supra* note 12, at 2667: "The AMA has stated that 'it is clear that addiction is not simply the product of a failure of individual willpower.' Substance abuse is caused by complex hereditary, environmental, and social factors. Individuals who are substance dependent have impaired competence in making decisions about the use of that substance." (citations omitted).



## III. CONCLUSIONS

The problem of substance-exposed babies is certainly a national tragedy. No one can deny that these babies' mothers deserve some of the blame for their children's problems. As this Current Topic has noted, however, we already have a generation of children in America's inner cities who, for various reasons, are wreaking havoc on their neighborhoods, their communities, and even themselves. Those advocating prosecution often act as if all parents give birth to and raise healthy children, except those mothers on drugs, who will cause the ruin of America's next generation.

One reason for the problems of the present generation undoubtedly lies in the breakdown of family structures. More and more women, especially poor women, are raising children without the men who impregnated them. Yet very few voices are heard advocating the criminal sanction for these men. Nor do we hear voices clamoring to incarcerate the parents of 70% of female substance abusers who so tremendously influenced the later substance abuse of their daughters. Instead, those prosecuting maternal substance abusers have chosen one well-publicized and particularly heart-wrenching aspect of this crisis and have chosen to sanction those responsible for one part of it. Perhaps prosecution's advocates focus on maternal substance abusers because they see inflicting physiological harms on children as qualitatively different and more reprehensible than merely arresting a child's social or psychological development. It is doubtful, however, that many of these children's problems are purely physiological. And, as far as the children are concerned, the nature of their suffering probably does not make much difference.

In any event, allocating moral blame does not necessarily provide the best solution to a problem. The criminal model assumes that people have some degree of free will—that they choose to act as they do and can just as easily choose to act differently. By applying criminal sanctions to those who choose to act illegally, the state supplies an incentive not to act in the undesired manner. However accurate or inaccurate this model may be for other forms of criminal behavior, it is simply not applicable to the problem of maternal substance abuse. Experience shows that it is nearly impossible to kick a drug addiction without treatment, and there is almost no treatment available to these women. Moreover, merely stopping the illegal act of substance abuse during pregnancy will not ensure the health of these babies. Prosecution consequently will only scare women away from what little advice and treatment is currently available to them. It will also hamper research, and stifle honest and confidential consultation between women and their doctors. And it will send an ever-growing number of high-risk children into a foster care system that is incapable of meeting their needs.

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Under certain conditions state punishment or mandatory rehabilitation of maternal substance abusers may not prove so unreasonable: if maternal drug use is the proven and primary cause of a drug-exposed child's disabilities; if the state also punishes male behavior that contributes to such problems; and most importantly, if treatment is available, so that prosecution will be society's best and only choice for curtailing the problem. But these conditions do not exist today. Instead, demand for treatment far exceeds supply, and what treatment exists is mostly inadequate to serve the needs of pregnant women. Until society can serve the needs of those who want treatment, it makes little sense to use prosecution either to displace those wanting treatment with those who do not or to send pregnant women to jail where they will have little opportunity to reform and their babies will have little chance to survive.

Moreover, I must emphasize that no matter what the moral or legal implications of prosecution may be, it simply is not a cost-effective policy. The United States will spend literally billions of dollars this year alone on the health care costs resulting from its failure to offer these women treatment. Given the experience thus far of those in the medical and treatment fields, prosecution can serve only to increase these costs.

Thus, the only chance for solving this problem and saving these babies is not prosecution, but comprehensive treatment. Certainly some of those prosecuting maternal substance abusers choose to prosecute, not because they believe it is the best course of action, but because it is the only one open to them. Policy makers should therefore create new forms of comprehensive treatment for pregnant addicts, based on programs such as Amity, Inc. and Mandella House. In order to deal with all of the causes of these babies' problems, such treatment must integrate drug treatment, health care for both mother and child, and parenting and skills training. This proposal for comprehensive care is not just another call for more money and more social services aimed simply at making these women better mothers and parents. Rather, it reflects the complexities of maternal substance abuse. It recognizes that if substance abuse is an intergenerational problem, we must adopt a policy that avoids turning the babies we feel sorry for today into those we wish to punish tomorrow. Moreover, it incorporates the realization that in designing treatment for this population, we cannot be bound by the idea that what works for men works for women. We cannot fall victim to the belief that men define the standard, and that anything women require that is different is not a necessity but an extra. If, as prosecutors and their detractors alike seem to agree, treatment is the answer, then we must formulate a treatment policy that has some chance of working. Thus, while society would benefit from teaching men to be better parents, dealing with the problem of maternal substance abuse requires giving this service to women. Otherwise these women's inability to cope with their children may remove any benefit derived from their abstention

from drugs or give them an excuse to resume drug use and consequently harm both their born children and any future children they may have.

Maternal substance abuse is not an isolated problem. Rather, it is in large part a manifestation of the hopelessness and demoralization that characterizes America's inner-cities. Until we begin to treat maternal substance abuse as the systemic problem it is, and offer comprehensive and coordinated treatment, we will continue to waste our financial and human resources, and the tragedy of drug-exposed babies will continue to plague our society.

APPENDIX

STATE BY STATE LIST OF WOMEN PROSECUTED  
FOR DRUG USE DURING PREGNANCY

Because no statute explicitly criminalizes the use of illicit substances during pregnancy, prosecutors have relied on a variety of theories to prosecute these actions. Prosecutors pursued the earliest of these cases, *e.g.*, *California v. Stewart*, *Ohio v. Gray*, *infra*, under abuse and neglect laws. Most of these prosecutions failed because most states do not consider fetuses to be persons. A number of prosecutors consequently began to charge women under statutes prohibiting the delivery or distribution of controlled substances to minors, on the assumption that after the child is born, but before the umbilical cord is severed, illicit substances pass from mother to child. *See, e.g.*, *Florida v. Johnson*, *Michigan v. Hardy*, *infra*.

The following is a list of women charged under various criminal theories, based primarily upon The A.C.L.U. Reproductive Freedom Project, *Memorandum: State by State Case Summary of Criminal Prosecutions Against Pregnant Women and Appendix of Public Health and Public Interest Groups Opposed to These Prosecutions* (Oct. 29, 1990) [hereinafter *State by State Summary*], and supported by other sources where noted. Most of these cases have not gone to trial, and it is difficult to find accurate information on the exact number, the identity, and the fate of women charged with crimes relating to their use of illicit substances during pregnancy. Consequently, this list is probably incomplete.

**Alaska**

*Alaska v. Grubbs*, No. 4FA S89 415 Criminal, slip op. (Sup. Ct. Aug. 25, 1989) (defendant sentenced to six months in jail and five years probation for criminally negligent homicide when her two week old son died from heart attack due to maternal cocaine use before his birth).

**California**

*California v. Stewart*, No. M508197, slip op. (Cal. Mun. Ct., San Diego, Feb. 26, 1987) (court dismissed charges of failure to provide for minor child because legislature did not contemplate statute imposing duty of care on pregnant women).

*Reyes v. Superior Court*, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (Cal. Ct. App. 1977) (court dismissed charges of child endangerment against heroin addict because legislature did not intend statute to apply to prenatal conduct).

**Connecticut**

*Connecticut v. Baez*, No. CR089-010-4414, slip op. (Conn. Super. Ct. filed July 31, 1989) (pregnant woman charged with risk of injury to her child when she swallowed one-quarter ounce of cocaine as police moved to arrest her). The charges against Ms. Baez were later dropped. *See generally* Daily News, Aug. 11, 1989, at 23; Hartford Courant, Aug. 29, 1989, at 1.

**Florida**

*Florida v. Jerez*, No. K89-16257 (Monroe County Ct. Jan. 11, 1990) (warrant issued) (warrant on child abuse charges issued against woman who used cocaine during pregnancy).

*Florida v. Gethers*, No. 89-4454CF10A, slip op. (Fla. Cir. Ct., 17th Cir. Nov. 6, 1989) (court dismissed charges of criminal child abuse against woman who used cocaine).

*Florida v. Johnson*, No. E89-890-CFA, slip op. (Fla. Cir. Ct., 18th Cir. July 13, 1989), *appeal pending*, *Johnson v. Florida*, No. 89-1765 (Fla. Dist. Ct. App., 5th Dist. 1989) (woman convicted of delivering cocaine to child through umbilical cord).

*Florida v. Black*, No. 89-5325, slip op. (Fla. Cir. Ct. Jan. 3, 1990) (woman convicted of passing cocaine to baby through umbilical cord and sentenced to 18 months in prison and 3 years probation).

*Florida v. Hudson*, No. K88-3435-CFA, slip op. (Fla. Cir. Ct. July 26, 1989) (charges of child endangerment and delivery of controlled substance to minor for giving birth to baby with cocaine in blood stream dropped when defendant pled to possession charge).

The A.C.L.U. reports that five other Florida women have been similarly charged with delivering cocaine to their children. *See State by State Summary, supra*, at 4-6.

**Georgia**

*Georgia v. Coney*, No. 14/403-404 (Super. Ct. of Crisp County filed Nov. 6, 1989) (woman indicted for distribution of cocaine to her fetus).

**Idaho**

The A.C.L.U. reports that a Pocatello, Idaho woman was charged with injuring her child as a result of cocaine use during pregnancy. *See State by State Summary, supra* at 7.

**Illinois**

*Illinois v. Green*, No. 88-CM-8256 (Cir. Ct. filed May 8, 1989) (woman charged with manslaughter when her child died, allegedly because of her

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drug use during pregnancy). A grand jury refused to indict Green. *See* N.Y. Times, May 27, 1989, at A19, col. 5.

### **Kentucky**

*Kentucky v. Welch*, No. 90-CR-006 (Cir. Ct. Boyd County May 25, 1990) (woman addicted to percadin convicted of criminal child abuse when son was born allegedly suffering from neonatal abstinence syndrome). The A.C.L.U. is currently participating in Ms. Welch's appeal.

### **Massachusetts**

*Massachusetts v. Pellegrini*, No. 87970 (Super. Ct. filed Aug. 21, 1989) (judge dismissed charges against woman charged with distributing cocaine to her child through umbilical cord). *See* Boston Globe, Aug. 23, 1989, at 1.

### **Michigan**

*Michigan v. Hardy*, No. 12845, slip op. (Mich. Ct. App. April 1, 1991) (court dismissed delivery charges against maternal substance abuser because court "cannot reasonably infer that the legislature intended this application"). *See* Hoffman, *Pregnant, Addicted--and Guilty?*, N.Y. Times, Aug. 19, 1990, § 6 (magazine), at 44.

*Michigan v. Cox*, No. 9053545FH (Cir. Ct. for Jackson County filed Jan. 30, 1990) (woman charged with delivery of cocaine through umbilical cord).

*Michigan v. Bremer*, No. 90-1313-FY (Dist. Ct. Muskegon County) (court dismissed charges against woman charged with delivery of cocaine through umbilical cord because legislature did not intend delivery statute to apply to such situations). *See* N.Y. Times, Feb. 5, 1991 at B6, col. 4 (reporting that Bremer's prosecutor intends to appeal).

### **Nevada**

*Nevada v. Bloxham*, No. RJC-36887 (Reno Justice Ct. filed Feb. 2, 1990) (woman charged with child abuse after newborn tested positive for illicit drugs).

*Nevada v. Peters*, No. 90-241 (Sparks Justice Ct. filed Feb. 2, 1990) (woman charged with child abuse after newborn tested positive for illicit drugs).

### **North Carolina**

*North Carolina v. Inzar*, No. 90 CRS 6960 6961 (Sup. Ct. Robeson County filed April 16, 1990) (woman who allegedly smoked crack day before giving birth to brain-damaged child charged with assault with a deadly weapon and distributing cocaine to minor).

**Ohio**

*Ohio v. Andrews*, No. JU 68459 (Ohio C.P., Stark County June 19, 1989) (court dismissed charges of child endangerment for alleged cocaine use during pregnancy because statute only covers children born at time of endangering activity).

*Ohio v. Gray*, No. CR88-7406, slip op. (Ohio C.P., Lucas County July 13, 1989) (court dismissed child endangerment charges for alleged cocaine use during pregnancy because statute does not include fetuses within its protection).

**South Carolina**

The A.C.L.U. and various media sources report that upwards of 20 women in Charleston and Greenville have been charged with criminal neglect or distribution in South Carolina. *See State by State Summary, supra*, at 12; *see also* N.Y. Times, Feb. 5, 1990, at A14, col. 1; National Law Journal, Oct. 16, 1989, at 1, 28.

**South Dakota**

The A.C.L.U. reports that a Native American woman in South Dakota was sentenced to six months in jail for contributing to the dependency of a minor and ingestion of a toxic substance when her newborn tested positive for cocaine. *See State by State Summary, supra*, at 12-13.

**Texas**

*Texas v. Rodden*, No. 373625R (Dist. Ct. Tarrant County filed June 1, 1989) (woman charged with injury to child when she gave birth to baby who was allegedly addicted to cocaine). The charges were later dismissed when prosecutors discovered that Rodden also legally took methadone, and it was thus impossible to tell which drug caused the infant's withdrawal symptoms. *See State by State Summary, supra*, at 13-14; Dallas Morning News, July 19, 1989, at 1.